FIRST
Do No Harm

Patient Care Assessment Division, Board of Registration in Medicine

October, 2007

In this issue:

Fairlawn Rehab Hospital Takes Initiative in Wound Care

Pressure ulcers represent a serious problem for rehabilitation patients. Wound care is expensive, consumes resources, lengthens hospital stays, limits independence, compromises health and opens the door for potential litigation.

At Fairlawn Rehabilitation Hospital in Massachusetts, a multidisciplinary team was convened in the fall of 2005 to focus on strategies to decrease the wound prevalency rate. The team consisted of nurses, physical and occupational therapists, a dietician, physician assistant and nurse practitioner. The team set a goal to reduce nosocomial wounds by 50% within one year.

Strategies to accomplish this goal included:

- The development of a wound team to become "wound experts" using evidenced-based (or best) practice.
- Development of a consultative service defining access standards, formal assessments, treatment protocols and required documentation.
- Weekly wound rounds and staff/patient education.

The process involved the development of new assessment tools, a wound care formulary and wound cart. The team approach provided a comprehensive assessment of the patient's pain, nutritional status along with seating, prosthetics, footwear and other devices that effect wounds.

Following implementation of the Wound Care Team, the wound prevalency rate decreased from 10% in January, 2006 to 0% in January 2007. Our success has been recognized by the Massachusetts Hospital Association as well as local facilities who continue to consult with our team.

Contributed by Mary Aleksiewicz, Vice President of Nursing at Fairlawn Rehabilitation Hospital in Worcester, Massachusetts. She presented a paper outlining these findings at the Association of Rehabilitation Nurses Annual Conference in Washington, DC on October 6, 2007.

Award for Excellence in Patient Safety

North Shore Medical Center

For developing a transparent, collaborative multidisciplinary peer review process that includes nursing peer review, and physician-led case analysis and reporting to the Board's PCA Program.

An Interdisciplinary Approach to PCA

The North Shore Medical Center, like all hospitals, has had a peer review process and Patient Care Assessment Committee (PCAC) in place for many years. Over time, traditional mortality and morbidity rounds, departmental peer review and PCAC meetings that once were open only to physicians, have been replaced by a multidisciplinary peer review process with a broader focus. This transformation has offered the opportunity to look at care across disciplines and to consider the role systems, teamwork and communication processes play in adverse outcomes.

The NSMC PCAC, a "governing board level" medical peer review committee, is co-chaired by the Chief Medical Officer and the President of the Medical Staff, and staffed by the Patient Care Assessment Coordinator. In addition to all Department Chairs and select physician leaders, the Chief Nursing Officer, Directors of Patient Safety and

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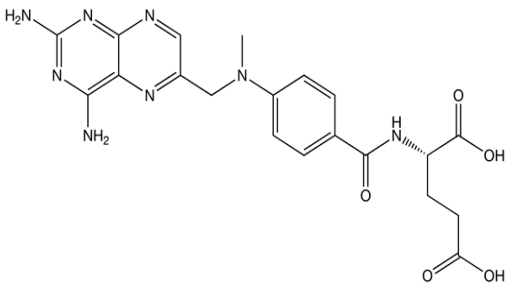
A Warning About Oral Methotrexate Dosing

Methotrexate, a well-established chemotherapeutic agent, is now used in low oral doses for treatment of other conditions such as rheumatoid arthritis, psoriasis and inflammatory bowel disease. Two Safety and Quality Reviews reported to the PCA have raised our awareness of the potential for "mix-ups" due to the expanded use of this medication.

In its April 3, 2002, newsletter, the Institute for Safe Medication Practices (ISMP) described this problem and made a Safe Practice Recommendation for reducing the risk of error when oral methotrexate is prescribed. In light of these PCA reports, we thought it beneficial to share the ISMP's recommendations with you. The full ISMP article follows.

Beware of Erroneous Daily Oral Methotrexate Dosing*

The perils of low-dose oral methotrexate are clearly evident in the dozens of fatalities reported in patients who have been prescribed this cytotoxic agent for alternative conditions. While methotrexate has a well-established role in oncology, increasingly it's being used in low doses for immunomodulation in rheumatoid arthritis, asthma, psoriasis, inflammatory bowel disease, myasthenia gravis, and inflammatory myositis. Used for these purposes, it's administered as a weekly dose. But mistakes have been all too frequent because relatively few medications are dosed in this manner and clinicians and patients are much more familiar with daily dosing of medications. For example, one patient died after he misunderstand the directions for use and took methotrexate 2.5 mg every 12 hours for six consecutive days, instead of 2.5 mg every 12 hours for three doses each week. Another patient died after he misread the directions on a prescription bottle and took 10 mg every "morning" instead of every "Monday." Errors also have been reported with hospitalized patients. In one case, the physician had properly recorded that the patient had been taking methotrexate 7.5 mg weekly as an outpatient. But when he prescribed three 2.5 mg tablets weekly, it was transcribed incorrectly as three times daily. Upon transfer to another unit, the dose was transcribed incorrectly as three times a week. In each case the errors did not reach the patient because they were detected during pharmacy review of the order. Similar errors have been reported overseas. For example, in Australia, one patient took extra doses of methotrexate as needed to relieve ar-



thritic symptoms. Three elderly patients took the medication daily despite clearly written instructions to take it weekly. Two cases involved incorrect transcription of the dosing schedule with hospitalized patients. Three of the six patients died as a result of the errors.

SAFE PRACTICE RECOMMENDATION: Because of the number of fatalities from errors with oral methotrexate, clinicians should consider it a high alert medication. As such, there are several measures that can help reduce the risk of an error when oral methotrexate is prescribed:

- Build alerts in electronic prescribing systems and pharmacy computers to warn clinicians whenever doses of oral methotrexate have been entered (and to remind staff to check the indication with the patient in a retail setting). Configure the systems to avoid defaulting to a daily dosing schedule.
- Have a pharmacist conduct a prospective drug utilization review before dispensing oral methotrexate to determine its indication for use, verify proper dosing, confirm the correct dosing schedule on medication administration records and prescription labels, ensure staff and patient education, and promote appropriate monitoring of the patient.
- Establish a system that ensures that outpatients receive counseling when picking up new prescriptions and refills (e.g., mark the bag with a red flag to alert clerical staff that counseling is required, not optional).
- Provide patients with clear written instructions that name a specific day of the week for taking the tablet(s). When possible avoid choosing Monday since it could be misread as "morning." Prepare instructions in big print to assist elderly patients with poor eyesight.
- Advise patients to contact their physician if they miss taking a dose. Tell them that a flare-up of the disease is unlikely with one missed dose.
- Ensure that written drug information leaflets are given to patients and that they contain clear advice about the weekly dosage schedule, not a daily dosing schedule.
- Explain to patients that taking extra doses is dangerous. Encourage feedback to ensure that the patient understands the

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McLean Hospital – Suicide Risk Assessment Part II

This is a follow up to the Board of Registration in Medicine's Patient Care Assessment Division's June 2007 publication, "FIRST Do No Harm," in which the McLean Hospital Risk Assessment Tool was described. As previously noted, the Joint Commission ranks suicide as the 11th most frequent cause of death in the United States. The Risk Assessment Tool was developed in an effort to assess risk of suicidal or aggressive behavior with the goal of minimizing this risk in the patients we serve.

The following is a summary of the content of the Tool. During the admission patient evaluation at the Clinical Evaluation Center at McLean, the following items on the Tool are rated individually by severity (none or n/a, Low, Moderate, or Severe) by the admitting clinician: current suicidal ideation; recent suicide attempt; recent threats or harm towards others; recent threats or destruction of property; history of suicidal ideation; history of threats or harm toward others; history of threats or destruction of property; severe mood symptoms; agitation/panic attacks/impulsivity; drug/alcohol use or withdrawal; delusion that increases risk; command auditory hallucinations concerning self-harm or aggression; recent losses or relationship problems; employment or living situation problems; chronic pain or disabling medical illness; lack of family/social support; and lack of treatment alliance. Positive Factors that reduce risk are then considered by the clinician. Finally, an overall formulation provides the clinician with the opportunity to weigh and integrate the items above with an overall assessment of risk of suicidal or aggressive behavior, and to formulate a safety plan.

This Risk Assessment Tool is utilized as the first formal safety assessment that our patients receive upon admission to the McLean Clinical Evaluation Center. However, the downside of doing a formal Risk Assessment is that it might provide a sense of false security as the patient's condition, circumstances and thinking change. Thus, this initial Tool is not intended to be a substitute for ongoing comprehensive safety assessments. From point of admission forward, suicide risk assessment is done by members of the patient's multidisciplinary treatment team.

The tool is used as a foundation on which patient safety factors are considered, and hopefully, minimizes any devastating safety concerns for the patients served by us. A full description of the Risk Assessment Tool is in the June 2007 newsletter at : http://www.massmedboard.org/pca/pdf/jun07_news_letter.pdf.

Contributed by Dr. Gail Tsimprea, Chief Quality and Risk Management Officer for McClean Hospital in Belmont, Massachusetts.

Peer Review Conference Draws Record Attendance

The Patient Care Assessment Division's peer review conference held at the State House on September 20th was a tremendous success. The Great Hall was filled to capacity with over 200 attendees, representing 80 hospitals. PCA's guest lecturer, Dr. Leslie Selbovitz, Chief Medical Officer and Senior Vice President for Medical Affairs at Newton Wellesley Hospital, described the hospital's medical staff peer review process. He shared his "Teaching Principle of Quality," the standard by which the hospital medical staff reviews the quality of care provided to patients. *"Unless each and every component of care was/is delivered in the exact fashion in which you would teach it, there is opportunity for improvement."* Dr. Selbovitz's willingness to share the Newton Wellesley experience received a positive response from those in attendance, many noting that he was an effective and engaging speaker.

This program focused on the peer review process developed by one hospital. All hospitals are unique, and their peer review and credentialing structures vary.

Above: Dr. Leslie Selbovitz

The PCA Division's goal is to share lessons learned by other facilities in the Commonwealth and we don't advocate for any one way of performing these important functions. As long as a health care facility is demonstrating that its processes are effective in improving the quality and

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NSMC

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Risk Management are committee members. In addition, others are invited if they had involvement in cases being discussed and can offer insight into the discussion. Those individuals might include the Medical Director of the Trauma Program, the Quality Specialists, a Clinical Program Director or a Nurse Manager.

In January 2007, the NSMC PCAC established a sub-committee to focus specifically on Nursing practice issues. In accordance with the NSMC Patient Care Assessment Plan, complications, adverse outcomes, medical errors and other concerns are identified through a routine case screening process and other internal reporting mechanisms. When it is determined that further investigation and/or follow-up is needed, cases are referred for formal peer review to the appropriate PCAC medical department sub-committees (s), including the new nursing department subcommittee. The goal is to refer cases for further review to all involved specialties simultaneously so the results can be synthesized to create a complete picture of the course of events in a timely manner. For cases with more than one involved department, a lead physician is identified. The other sub-committees are responsible for summarizing their review findings and recommendations, and forwarding them to the lead physician who incorporates the information into the case report for the NSMC PCAC.

At the PCAC meeting, a scribe records discussion and recommendations, and sends a summary to the lead physician who incorporates those findings into the final Safety and Quality Review report submitted to the Board of Registration in Medicine. While the Patient Care Assessment Coordinator manages the Quarterly Report submission process, the reports are written by the physicians who have intimate knowledge of the cases.

Standardized templates and other tools have been developed to guide report writing. The components of the Board's new Safety and Quality Review report have been incorporated into the templates to minimize reformatting of reports in the event a case is selected for submission. In addition to the description of the case, issues, corrective action plans and the practitioner performance summary, a paragraph describing disclosure, apology and discussions held with the patient and/or family has been added to the report template.

The Patient Care Assessment process at NSMC has evolved over time from closed door case review to a more transparent assessment of the processes and conditions affecting safe, effective patient care. There is stronger emphasis on safe practices, standardization and individual accountability than in the past and the impact of collaboration across departments has been very positive.

This article was contributed by Jennifer Costain, MS, CPHQ, Vice President, Performance Improvement and Patient Safety, and PCA Coordinator at North Shore Medical Center

METHOTREXATE

(Continued from "A WARNING ABOUT METHOTREXATE DOSING" - page 2)

weekly dosing schedule and that the medication should not be used "as needed" for symptom control.

- Solicit help from a responsible caregiver if the patient appears to have cognitive or severe sensory difficulties.
- Prescribe the drug as a dose pack (e.g., RHEUMATREX by Lederle), which helps to reinforce the weekly dosing schedule.

*** ISMP Medication Safety Alert. Institute for Safe Medication Practice. Newsletter April 3, 2002.**

PEER REVIEW CONFERENCE

(Continued from "PEER REVIEW CONFERENCE DRAWS RECORD ATTENDANCE" - page 3)

safety of medical care, PCA is satisfied. If your facility does make any changes to its peer review and credentialing processes, please be sure to consult hospital counsel to assure that these changes are in compliance with state and federal mandates.

For those who attended, time did not allow for a response to all of the questions submitted. If we did not have an opportunity to address any of your questions, please contact us. The conference was videotaped and should be available on the Board's website within the next few months.

AANA Honors Janet Dewan, CRNA

Janet Dewan, member of the PCA Committee and Certified Registered Nurse Anesthetist (CRNA), has been named the 2007 Didactic Instructor of the Year by the American Association of Nurse Anesthetists (AANA). The Didactic Instructor of the Year Award, established in 1991, is presented to an individual who has made a significant contribution to the education of student nurse anesthetists in the classroom.

Dewan is currently the associate program coordinator and clinical specialist in the nurse anesthesia program at Northeastern University School of Nursing in Boston. In addition, she is a staff anesthetist at Tuft's NEMC Hospital, and Winchester Anesthesia Associates in Boston.

Dewan has been actively involved in nurse anesthesia education for more than 25 years, and has enhanced the Northeastern program in numerous ways, which includes securing funding for the program's simulation laboratory. Her attributions have resulted in improved teaching materials that help with instructing students in fiberoptic intubations, spinal and epidural mannequins, modern anesthesia machines, and other teaching devices. In addition to her other contributions to the profession, Dewan served for nine years on the Massachusetts Board of Nursing. She has been a member of the Patient Care Assessment Committee since 2003. She is also a candidate for a PhD in Law, Policy and Society from Northeastern University.

A CRNA for nearly 30 years, Dewan received her master's degree in nursing from New York Medical College in Valhalla, NY, and her nurse anesthesia diploma from New England Medical Center School of Nurse Anesthesia in Boston, Mass. In addition, she earned a Bachelor of Arts degree from Douglass College, Rutgers University, New Brunswick, New Jersey.

PCA Welcomes New Intern

This month, the PCA Division would like to welcome Layne Anderson, the new intern associate here at the Board of Registration in Medicine. Ms. Anderson joins the PCA from Emerson College, where she is finishing her senior year as a Political Communications major. She will be working with the PCA until her graduation in December of this year.

Contact PCA

To be added to the PCA Newsletter and advisory mailing list, please visit http://www.lists-massmedboard.org/mailman/listinfo.cgi/pca.

To submit articles to PCA, update hospital contact information, request an SQR form or to make comments or ask questions, please send an e-mail to first@state.ma.us, call 617.654.9896 or send mail to: Board of Registration in Medicine; PCA Division; 560 Harrison Avenue; Boston, MA 02118.

Safety and Quality Reviews - What Have We Seen?

We frequently see Safety and Quality Reviews describing patients who received sedatives for restlessness and anxiety without first undergoing a bedside clinical assessment by a physician. By masking the signs of deteriorating respiratory function, the sedatives delayed recognition of the underlying cause of the respiratory compromise.